Medical Assistance Provider Bulletin

Attention: All Title XIX Certified Rehabilitation Agencies, Occupational Therapists, Physical Therapies, Speech Therapists and Speech/Hearing Clinics

Subject: New HCFA 1500 Claim Form, Revised Prior Authorization and Billing Instructions

Date: March 27, 1992

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Department of Health and Social Services, Division of Health,
Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701

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I. INTRODUCTION

This Medical Assistance Provider Bulletin (MAPB) provides important information on the Wisconsin Medical Assistance Program's (WMAP) implementation of a new HCFA 1500 claim form and revised prior authorization and billing instructions for durable medical equipment. **It is important that providers review this information carefully and share it with billing staff.**

II. NEW NATIONAL HCFA 1500 CLAIM FORM (12/90)

The Health Care Financing Administration (HCFA) has mandated that all state Medicaid programs use the revised National HCFA 1500 claim form (dated 12/90). All paper claims received by EDS from March 15, 1992, through May 1, 1992, may be submitted on either the current HCFA 1500 claim form (dated 1/84) or the new claim form.

All claims, including the resubmission of any previously denied claims, received by EDS after May 1, 1992, must be submitted on the HCFA 1500 claim form dated 12/90. Claims received by EDS after May 1, 1992, on claim forms other than the HCFA 1500 (12/90) claim form, will be denied. Modified versions of the National HCFA 1500 claim form may also be denied.

Please allow ample mailing time to ensure that claims submitted on the current HCFA 1500 claim form are received at EDS by May 1, 1992.

Crossover claims for Medicare Part B coinsurance and deductible allowed charges may be submitted on either the new or old HCFA 1500 claim form.

There are no changes to the submission of electronic claims.

A sample claim form and detailed claim form completion instructions are included in Attachments 1 and 2 of this MAPB. All claims received by EDS on the new HCFA 1500 claim form must be completed according to these instructions. The instructions in this MAPB completely replace the instructions that you received in MAPB-087-013-D/014-D/016-D dated September 1, 1987.

As you read the completion instructions in Attachment 2, please watch for the following changes:

- The procedure code is now indicated in Element 24D of the claim form, but the procedure code description is no longer required.
- The performing provider number is now required in Element K for each line item of the claim form, but the performing provider name is no longer required.
- An emergency condition must be indicated for each applicable line item on the claim form by entering an "E" in Element 24I.
- Services resulting from HealthCheck (EPSDT) referrals must be indicated for each applicable line item on the claim form by entering "H" for HealthCheck services in Element 24H.

The National HCFA 1500 claim form is not provided by either the WMAP or EDS, but may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.
P.O. Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

III. PLACE OF SERVICE CODES

Until further notice, the WMAP will continue to require the single-digit place of service codes on the HCFA 1500 claim, not the two-digit place of service codes required by Medicare. Claims with Medicare Part B allowed charges that cross over to the WMAP from WPS will have the place of service codes automatically converted to single-digit codes for claims processing. However, paper crossover claims, as well as all paper and electronic claims submitted directly to the WMAP, must indicate the appropriate single-digit place of service code.

IV. CORRECTIONS TO DME INDEX

There are two changes to the DME Index issued with MAPB-023-D dated December 15, 1991. These changes are effective with claims received at EDS on or after April 1, 1992. Attachment 3 of this MAPB contains a replacement for page 3 of the DME Index. Please remove and destroy page 3 of the DME Index. Insert the replacement page.

Procedure Code E0179 has a new description: "Dry Pressure Pad or Cushion, Non-positioning (e.g., eggcarte). A new procedure code, W0905, has been created and is defined as "Bathroom Equipment, includes rails, seats, stools, benches, any type."

V. PRIOR AUTHORIZATION AND BILLING FOR SERVICES USING A NON-SPECIFIC, "NOT OTHERWISE CLASSIFIED" OR REPAIR PROCEDURE CODE

This replaces some of the information contained in MAPB-090-021-D, dated August 10, 1990.

Nonspecific procedure codes, or "not otherwise classified" codes are to be used only when there is not a distinct procedure code for the service being provided. Whenever possible, use the most specific codes available, rather than general codes such as E1399 and W6891.

The WMAP is implementing a new way to process nonspecific, "not otherwise classified," and repair procedure codes. Effective with prior authorization requests received by EDS on and after April 1, 1992, the maximum allowable reimbursement for these codes will be determined when the prior authorization is approved. Reimbursement is then the billed amount or the amount on the Prior Authorization Request Form (PA/RF), whichever is less.

This means that repair codes and nonspecific codes can be billed electronically or billed by using the revised HCFA 1500 for dates of service on or after April 1, 1992. Refer to Attachment 4 of this MAPB for the list of nonspecific codes priced under this new process.

Process for Requesting Prior Authorization and Submitting Claims for Nonspecific Codes and Repair Codes

A. Submitting a Prior Authorization Request Form (PA/RF)

1. Include a description of each item with a nonspecific procedure code in sufficient detail to enable the WMAP to set the maximum allowable reimbursement. This must include the manufacturer's item description (e.g., name and model number).

2. Do not include a modifier in element 15 unless modifier "01" is necessary to indicate a bilateral procedure. (Refer to "Receiving an Approved PA/RF" and "Billing for Nonspecific Codes" for further information on modifiers.)

3. Always indicate a quantity of "1" in element 19 for nonspecific codes. If requesting two identical items within a nonspecific code, identify this as a "pair" in the description or by using a bilateral modifier when allowed. Effective April 1, 1992, procedure codes W6849, W6891, and E1399 will no longer be authorized as bilateral services, but may be requested as a pair. If requesting a series of services, (e.g., serial splints) include the number of splints in the description and quantity of "1" in element 19. These procedure codes should be billed once per prior authorization number upon completion of service.

B. Submitting a Prior Authorization Durable Medical Equipment Attachment (PA/DMEA). (For procedure code W6999, submit Prior Authorization Aid Request Form 1 (PA/ARF1).

Where relevant, include justification of why less expensive equipment is inappropriate for the recipient.

C. Receiving an Approved PA/RF

1. The maximum allowable reimbursement is indicated for repair and nonspecific procedure codes in element 20. This is initialed and initiated by the state consultant.

2. If several items are approved under one nonspecific code, procedure code modifiers (numbers 11-22) are assigned in element 15 to each approved item by the consultant.

D. Submitting Amendments to An Approved PA/RF

1. The only way to obtain a higher level of reimbursement than is identified on the PA/RF for nonspecific codes is by submitting a prior authorization amendment request. An amendment may be submitted if the provider can document that the approved maximum allowable reimbursement does not cover the cost of parts or repairs.

2. If an amended PA/RF is approved after you have received reimbursement, submit an adjustment request for additional reimbursement which indicates that the prior authorization maximum has been changed. Refer to Part A Section IX of the WMAP Provider Handbook for information about adjustment requests.

E. Billing for Nonspecific Codes

1. Use a quantity of "1" to bill for each detail of a nonspecific code.

2. When a modifier is assigned to a nonspecific procedure code on the approved PA/RF, the modifier must be used when billing for the specific authorized items.

3. Reimbursement is the billed amount or the amount approved on the PA/RF, whichever is less.

Refer to Attachments 5, 5a, and 1 for a sample PA/RF submission, PA/RF approval and claim.

VI. CHANGES IN PRIOR AUTHORIZATION LIMITS

A lower prior authorization dollar threshold has been established for certain custom and repair codes effective for dates of service on or after May 1, 1992. Refer to Attachment 6 for a list of these codes and the new dollar thresholds. Claims for these services which exceed the new dollar threshold and are submitted without a Prior Authorization number will be denied. Please note these changes in your DME Index issued December 15, 1991.

Reimbursement for these services which exceed the prior authorization threshold will be established through the Prior Authorization process described in Section V of this MAPB. Reimbursement for these services which fall below the threshold will be paid at a rate established by the Department of Health and Social Services.

For repair codes, providers are reminded that the dollar threshold amounts are per entire repair service. If it takes two days to repair an adaptive communication device and the completed cost exceeds the threshold, it is not appropriate to break the repair in two parts. If a provider must repair two different parts to get the adaptive communication device running again, the repair should not be billed as two repairs. For purposes of the prior authorization threshold, the WMAP considers each of these examples single repairs. The provider must indicate on the claim form the exact date or dates on which the service occurred and indicate a quantity of "1" for each repair code.

If providers need to make immediate, emergency repairs to make an adaptive communication device operating again, but the repairs will exceed the dollar threshold, they may request backdating of the Prior Authorization request. Requests for emergency Prior Authorization with backdating must be received by EDS within two weeks of the date of service, since Prior Authorizations cannot be backdated more than 14 days from receipt date. The PA/RF must clearly state the request for backdating, the reason backdating is requested, and must indicate the date of service. Procedures for requesting backdating are indicated in Section VIII - F of Part A, the All Provider Handbook.

VII. BILLING FOR UNLISTED SPEECH/HEARING CLINIC PROCEDURE CODE 92599

Claims for 92599 (unlisted otorhinolaryngological service or procedure) require documentation describing the procedure performed. The provider may use element 19 of the HCFA 1500 claim form (Reserved for Local Use), if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "see attached" in element 19 and attach additional documentation. This documentation may be in the form of a physician's prescription, history and physical exam report, or a medical progress report. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for procedure code 92599 which do not have the documentation either on the claim or attached to the claim form will be denied.

VIII. 1992 CURRENT PROCEDURAL TERMINOLOGY (CPT)

The Department of Health and Social Services is currently in the process of identifying appropriate coverage and pricing policies for the new durable medical equipment procedures identified in the 1992 Current Procedural Terminology published by the American Medical Association. Providers should continue to use the allowable procedures identified in the Durable Medical Index issued December 15, 1991, as modified by this MAPB until further notice. Claims for DME procedures which were newly added to the CPT in 1992 will be denied. We anticipate that appropriate new codes will be added, effective for dates of service on or after July 1, 1992.